

CHILD CARE PERSONNEL HEALTH FORM

NAME OF CHILD CARE PROGRAM: _____

NAME & ADDRESS OF EMPLOYEE: _____

MY SIGNATURE BELOW AUTHORIZES THE RELEASE OF THE FOLLOWING MEDICAL INFORMATION TO THE ABOVE NAMED CHILD CARE PROGRAM AND TO THE BUREAU OF CHILD CARE LICENSING.

EMPLOYEE SIGNATURE

DATE SIGNED

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH PRACTITIONER.

TUBERCULIN TEST (REQUIRED FOR HIGH RISK INDIVIDUALS ONLY)

(IF YOU HAVE QUESTIONS ABOUT WHO MAY BE HIGH RISK, YOU MAY CONTACT THE TB PROGRAM FOR INFORMATION AT 1-800-852-3345, EXT. 4469 IN NH, OR OUTSIDE NH AT 603-271-4469)

TUBERCULIN SKIN TEST TYPE (MANTOUX RECOMMENDED): _____ DATE OF TEST _____

DATE OF INTERPRETATION _____ FINDINGS: _____ (mm induration)

POSITIVE TUBERCULIN SKIN TEST MUST BE FOLLOWED UP BY A CHEST X-RAY AND REFERRAL TO A NH TB PROGRAM (271-4469)

DATE AND FINDINGS OF CHEST X-RAY: _____

PHYSICIAN'S COMMENTS: _____

IMMUNIZATIONS: ITEMS 1 THROUGH 4 ARE RECOMMENDED, NOT REQUIRED BY LICENSING RULES

1. RUBELLA: DATE OF IMMUNIZATION: _____ OR DATE OF TITER: _____

2. MEASLES (RUBEOLA): DATE OF IMMUNIZATION(S): _____ OR DATE OF TITER: _____

DATE OF DISEASE (MUST HAVE BEEN PHYSICIAN DIAGNOSED): _____

3. TETANUS/DIPHTHERIA (TD): DATE OF IMMUNIZATION: _____

4. HEPATITIS B: DATE IMMUNIZATION SERIES COMPLETED: _____

PLEASE INDICATE BY CHECKING BELOW, ANY CURRENT OR PREVIOUS ILLNESS WHICH COULD IMPACT THE EXAMINEE'S ABILITY TO ADEQUATELY CARE FOR CHILDREN.

	YES	NO		YES	NO
UNKNOWN TUBERCULOSIS OR OTHER PULMONARY PROBLEMS <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UNKNOWN FAINTING AND DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR NEUROLOGICAL CONDITION <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	SERIOUS DEFECTS OF BONES & JOINTS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER CHRONIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER COMMUNICABLE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL OR EMOTIONAL DISTURBANCE	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL OR DRUG DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
SPECIFICS REGARDING ANY OF THE ABOVE CONDITIONS: 					

PLEASE LIST ANY MEDICATION CURRENTLY PRESCRIBED, WHICH COULD EFFECT HIS/HER ABILITY TO CARE FOR CHILDREN:

IMPRESSION OF PRESENT STATE OF HEALTH:

RECOMMENDATION: BASED UPON THE ABOVE INFORMATION I RECOMMEND THE FOLLOWING: (PLEASE CHECK ONE)

☐ THIS PATIENT HAS NO APPARENT HEALTH PROBLEMS WHICH WOULD PROHIBIT HIS/HER EMPLOYMENT CARING FOR CHILDREN.

CHILD CARE PERSONNEL HEALTH FORM

☐ BECAUSE OF THE CONDITIONS NOTED ABOVE I DO NOT RECOMMEND THAT THE EXAMINEE BE EMPLOYED CARING FOR CHILDREN. (IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE OF FORM)

DATE OF EXAMINATION: _____

SIGNATURE OF LICENSED HEALTH PRACTITIONER

DATE SIGNED

PLEASE TYPE OR PRINT NAME AND ADDRESS OF LICENSED HEALTH PRACTITIONER